

		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0038455</u></p> <p>Facility Name: <u>Alden Village Health Facility</u></p> <p>Address: <u>267 E. lake St.</u> <u>Bloomington</u> <u>60108</u> Number City Zip Code</p> <p>County: <u>DuPage</u></p> <p>Telephone Number: <u>(630) 529-3350</u> Fax # <u>(630) 529-9866</u></p> <p>IDPA ID Number: <u>36-3845800</u></p> <p>Date of Initial License for Current Owners: <u>11/02/92</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input checked="" type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Steven M. Kroll</u> Telephone Number: <u>(773) 286-3883</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/00</u> to <u>12/31/00</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td data-bbox="1150 678 1283 829" rowspan="2">Officer or Administrator of Provider</td> <td data-bbox="1283 678 1923 716">(Signed) _____ (Date) _____</td> </tr> <tr> <td data-bbox="1283 716 1923 753">(Type or Print Name) <u>Steven M. Kroll</u></td> </tr> <tr> <td data-bbox="1150 829 1283 878" rowspan="2"></td> <td data-bbox="1283 829 1923 878">(Title) <u>Chief Financial Officer</u></td> </tr> <tr> <td data-bbox="1150 878 1283 1040" rowspan="4">Paid Preparer</td> <td data-bbox="1283 878 1923 915">(Signed) _____ (Date) _____</td> </tr> <tr> <td data-bbox="1283 915 1923 953">(Print Name and Title) _____</td> </tr> <tr> <td data-bbox="1283 953 1923 990">(Firm Name & Address) _____</td> </tr> <tr> <td data-bbox="1283 990 1923 1040">(Telephone) <u>()</u> Fax # ()</td> </tr> </table> <p align="center">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____	(Type or Print Name) <u>Steven M. Kroll</u>		(Title) <u>Chief Financial Officer</u>	Paid Preparer	(Signed) _____ (Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) <u>()</u> Fax # ()
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																	
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																																	
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																																	
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Officer or Administrator of Provider	(Signed) _____ (Date) _____																																		
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	Paid Preparer	(Signed) _____ (Date) _____																																	
(Print Name and Title) _____																																			
(Firm Name & Address) _____																																			
(Telephone) <u>()</u> Fax # ()																																			

STATE OF ILLINOIS

Page 2

Facility Name & ID Number Alden Village Health Facility# 0038455 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>109</u>	Skilled (SNF)	<u>109</u>	<u>39,894</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>109</u>	TOTALS	<u>109</u>	<u>39,894</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	<u>32,046</u>	<u>422</u>	<u>173</u>	<u>32,641</u>	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>32,046</u>	<u>422</u>	<u>173</u>	<u>32,641</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 81.82%

D. How many bed-hold days during this year were paid by Public Aid?

915 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)NoneF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 01/01/92

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 11/01/92 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____Medicare Intermediary AdminiStar Federal Inc.

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Alden Village Health Facility # 0038455 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	155,794	15,252		171,046		171,046		171,046		1
2	Food Purchase		485,611		485,611	(23,346)	462,265	(300,201)	162,064		2
3	Housekeeping	143,768	20,928	5,280	169,976	177	170,153	5,225	175,378		3
4	Laundry	88,648	10,830		99,478		99,478		99,478		4
5	Heat and Other Utilities			75,224	75,224		75,224		75,224		5
6	Maintenance	38,500		101,027	139,527	625	140,152	462	140,614		6
7	Other (specify):*										7
8	TOTAL General Services	426,710	532,621	181,531	1,140,862	(22,544)	1,118,318	(294,514)	823,804		8
	B. Health Care and Programs										
9	Medical Director			27,984	27,984		27,984		27,984		9
10	Nursing and Medical Records	2,053,211	132,692	44,771	2,230,674		2,230,674	(522)	2,230,152		10
10a	Therapy			11,185	11,185		11,185		11,185		10a
11	Activities	19,525	3,473	3,811	26,809		26,809		26,809		11
12	Social Services	36,435		154,709	191,144		191,144		191,144		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,109,171	136,165	242,460	2,487,796		2,487,796	(522)	2,487,274		16
	C. General Administration										
17	Administrative	71,247			71,247		71,247		71,247		17
18	Directors Fees										18
19	Professional Services			621,709	621,709		621,709	(423,862)	197,847		19
20	Dues, Fees, Subscriptions & Promotions			31,686	31,686	(625)	31,061	(20,203)	10,858		20
21	Clerical & General Office Expenses	297,160	15,018	18,995	331,173		331,173	106,903	438,076		21
22	Employee Benefits & Payroll Taxes			343,155	343,155	23,169	366,324	34,930	401,254		22
23	Inservice Training & Education										23
24	Travel and Seminar			21,543	21,543		21,543	8,836	30,379		24
25	Other Admin. Staff Transportation			5,481	5,481		5,481		5,481		25
26	Insurance-Prop.Liab.Malpractice			28,413	28,413		28,413	6,643	35,056		26
27	Other (specify):*										27
28	TOTAL General Administration	368,407	15,018	1,070,982	1,454,407	22,544	1,476,951	(286,753)	1,190,198		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,904,288	683,804	1,494,973	5,083,065		5,083,065	(581,789)	4,501,276		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Alden Village Health Facility

#0038455

Report Period Beginning:

01/01/00

Ending:

12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			37,162	37,162		37,162	107,969	145,131			30
31	Amortization of Pre-Op. & Org.							1,145	1,145			31
32	Interest			63,483	63,483		63,483	385,416	448,899			32
33	Real Estate Taxes			44,594	44,594		44,594	3,830	48,424			33
34	Rent-Facility & Grounds			672,000	672,000		672,000	(672,000)				34
35	Rent-Equipment & Vehicles			6,409	6,409		6,409	12,113	18,522			35
36	Other (specify):* MORT. INSUR.							43,345	43,345			36
37	TOTAL Ownership			823,648	823,648		823,648	(118,182)	705,466			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		12,085	65,266	77,351		77,351	(72,813)	4,538			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			340,212	340,212		340,212		340,212			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		12,085	405,478	417,563		417,563	(72,813)	344,750			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,904,288	695,889	2,724,099	6,324,276		6,324,276	(772,784)	5,551,492			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Alden Village Health Facility

0038455

Report Period Beginning: 01/01/00

Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(16,604)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(465)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(20)	32		18
19	Entertainment				19
20	Contributions	(100)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(15,423)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(4,713)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (37,325)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(727,307)	VARY	34
35	Other- Attach Schedule SEE PG 5A	(8,152)	VARY	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (735,459)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (772,784)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES			Sch. V Line
	Amount	Reference	
1 non-expense:hmo drug c/s (pl 5042)	\$ (2,877)	19	1
2 psic fees (non-allowable expense)	(59)	20	2
3 community relation (non allowable expense)	(260)	28	3
4 reclass painting>\$1500 for 2000 from ln 6 to pg 22	(13,129)	6	4
5 record deprec exp on painting reclass for 2000	2,188	6	5
6 record deprec exp on painting reclass for 1999	2,978	6	6
7 record deprec exp on painting reclass for 1998	3,000	6	7
8			8
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87			87
88			88
89			89
90 Total	(8,152)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden Village Health Facility

0038455

Report Period Beginning:

01/01/00

Ending:

12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(465)	0	0	(299,736)	0	0	0	0	0	0	0	(300,201)	2
3	Housekeeping	0	0	0	0	0	5,225	0	0	0	0	0	5,225	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(4,965)	0	5,427	0	0	0	0	0	0	0	0	462	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(5,430)	0	5,427	(299,736)	0	5,225	0	0	0	0	0	(294,514)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	(522)	0	0	0	0	0	0	(522)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	(522)	0	0	0	0	0	0	(522)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	8,652	(432,446)	0	0	0	0	(68)	0	0	0	(423,862)	19
20	Fees, Subscriptions & Promotions	(20,546)	0	343	0	0	0	0	0	0	0	0	(20,203)	20
21	Clerical & General Office Expenses	0	2,999	22,889	80,239	776	0	0	0	0	0	0	106,903	21
22	Employee Benefits & Payroll Taxes	0	0	37,203	0	(2,273)	0	0	0	0	0	0	34,930	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	8,836	0	0	0	0	0	0	0	0	8,836	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	6,549	94	0	0	0	0	0	0	0	0	6,643	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(20,546)	18,200	(363,081)	80,239	(1,497)	0	0	(68)	0	0	0	(286,753)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(25,976)	18,200	(357,654)	(219,497)	(2,019)	5,225	0	(68)	0	0	0	(581,789)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alden Village Health Facility

0038455

Report Period Beginning:

01/01/00

Ending:

12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	(16,604)	109,258	15,315	0	0	0	0	0	0	0	0	107,969 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	1,145	0	0	0	0	1,145 31
32	Interest	(20)	380,444	3,097	0	0	0	1,895	0	0	0	0	385,416 32
33	Real Estate Taxes	0	0	3,830	0	0	0	0	0	0	0	0	3,830 33
34	Rent-Facility & Grounds	0	(672,000)	0	0	0	0	0	0	0	0	0	(672,000) 34
35	Rent-Equipment & Vehicles	0	0	12,113	0	0	0	0	0	0	0	0	12,113 35
36	Other (specify):*	0	43,345	0	0	0	0	0	0	0	0	0	43,345 36
37	TOTAL Ownership	(16,624)	(138,953)	34,355	0	0	0	3,040	0	0	0	0	(118,182) 37
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	(2,877)	0	0	(9,884)	(8)	0	(60,044)	0	0	0	0	(72,813) 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	TOTAL Special Cost Centers	(2,877)	0	0	(9,884)	(8)	0	(60,044)	0	0	0	0	(72,813) 44
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	(45,477)	(120,753)	(323,299)	(229,381)	(2,027)	5,225	(57,004)	(68)	0	0	0	(772,784) 45

Facility Name & ID Number Alden Village Health Facility

0038455

Report Period Beginning:

01/01/00

Ending:

12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ALDEN MANAGEMENT SERVICES, INC.	100%	SEE PAGE 6K		SEE PAGE 6K		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V	34	RENTAL INCOME	\$ 672,000	VILLAGE, LLC.		\$	\$ (672,000)	1
2	V	32	INTEREST INCOME	46,901	VILLAGE, LLC.			(46,901)	2
3	V	21	G&A		VILLAGE, LLC.		2,999	2,999	3
4	V	19	ACCOUNTING FEE		VILLAGE, LLC.		8,652	8,652	4
5	V	30	DEPRECIATION		VILLAGE, LLC.		109,258	109,258	5
6	V	36	MORTGAGE INSURANCE		VILLAGE, LLC.		43,345	43,345	6
7	V	26	AMORITIZATION		VILLAGE, LLC.		6,549	6,549	7
8	V	32	INTEREST ON MORTGAGE		VILLAGE, LLC.		427,345	427,345	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 718,901			\$ 598,148	\$ * (120,753)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Village Health Facility

0038455

Report Period Beginning: 01/01/00

Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	6 maintenance/utilities	\$	Alden Management Services, Inc.		\$ 5,427	\$ 5,427
16	V	19 professional fees	439,883	Alden Management Services, Inc.		7,437	(432,446)
17	V	20 licenses/fees		Alden Management Services, Inc.		343	343
18	V	21 gen'l & admin		Alden Management Services, Inc.		22,889	22,889
19	V	22 employee costs		Alden Management Services, Inc.		37,203	37,203
20	V	24 auto/seminar		Alden Management Services, Inc.		8,836	8,836
21	V	26 insurance		Alden Management Services, Inc.		94	94
22	V	30 depreciation		Alden Management Services, Inc.		15,315	15,315
23	V	32 interest		Alden Management Services, Inc.		3,097	3,097
24	V	33 real estate tax		Alden Management Services, Inc.		3,830	3,830
25	V	35 auto lease		Alden Management Services, Inc.		12,113	12,113
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 439,883			\$ 116,584	\$ * (323,299)

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Village Health Facility

0038455

Report Period Beginning: 01/01/00

Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2 tube feeding	\$ 375,132	Pyramid Healthcare Services		\$ 75,396	\$ (299,736)	15
16	V	39 nursing supplies	19,481	Pyramid Healthcare Services		9,597	(9,884)	16
17	V	21 gen'l & admin		Pyramid Healthcare Services		80,239	80,239	17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 394,613			\$ 165,232	\$ * (229,381)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Village Health Facility

0038455

Report Period Beginning: 01/01/00

Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39 drugs	\$	Forum Extended Care II		\$	\$	15
16	V	10 house stock	2,110	Forum Extended Care II		1,588	(522)	16
17	V	39 iv	35	Forum Extended Care II		27	(8)	17
18	V	22 vaccinations	9,191	Forum Extended Care II		6,918	(2,273)	18
19	V	21 gen'l & admin		Forum Extended Care II		776	776	19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 11,336			\$ 9,309	\$ * (2,027)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	3 HOUSEKEEPING	\$ 5,543	TRIPOINT SERVICES	0.00%	\$ 10,768	\$ 5,225	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 5,543			\$ 10,768	\$ * 5,225	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Village Health Facility

0038455

Report Period Beginning: 01/01/00

Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39 CPT REVENUES	\$ 163,774	COMMUNITY PHYSICAL THERAPY	100.00%	\$ 103,730	\$ (60,044)	15
16	V	31 AMORTIZATION		COMMUNITY PHYSICAL THERAPY		1,145	1,145	16
17	V	32 INTEREST		COMMUNITY PHYSICAL THERAPY		1,895	1,895	17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 163,774			\$ 106,770	\$ * (57,004)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Village Health Facility

0038455

Report Period Beginning: 01/01/00

Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19 construction management fees	\$ 4,815	Alden Bennett Construction	0.00%	\$ 4,747	\$ (68)	15
16	V	19 architect/design	2,992	Alden Design Group		2,992		16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 7,807			\$ 7,739	\$ * (68)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

Page 7

Facility Name & ID Number Alden Village Health Facility # 0038455 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Floyd Schlossberg	President - AMS	CEO	100.00	187,719	1.38	3.46	Salary	\$ 6,727	21-1	1
2	Lauren Magnusson	Clinical Coordin.	nursing review	a.	71,913	1.38	3.46	Salary	2,577	21-1	2
3	Terry Magnusson	Administrator/other	admini / mainten.	b.	72,559	1.38	3.46	Salary	1,061	21-1	3
4	Audra Schlossberg-Elisco	Massage Therapist	massage therapy	c.	6851.00	0	0.00	fees	0	10a-3	4
5											5
6											6
7											7
8											8
9											9
10	a. Lauren is the daughter of Floyd Schlossberg and worked as a clinical coordinator for Alden Management Services in 2000										10
11	b. Terry is the son-in-law of Floyd Schlossberg. He was the administrator of Alden Valley Ridge for 7 months and in construction / misc. for 5 months in 2000.										11
12	c. Daughter of Floyd Schlossberg. Audra worked as a massage therapist for the year at various Alden facilities.										12
13								TOTAL	\$ 10,365		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME. ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Alden Village Health Facility# 0038455

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization ALDEN MANAGEMENT SERVICES, INC.
 Street Address 4200 W. PETERSON
 City / State / Zip Code CHICAGO, IL 60646
 Phone Number (773)286-3883
 Fax Number (773)286-3742

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	SEE PAGE 8A				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	CAMBRIDGE		X	MORTGAGE	\$56,000.00	4/1/99	\$ 5,957,425	\$ 5,916,215	3/31/19	7.2000	\$ 427,345	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	RELATED PARTY	X			NONE					VARIES	3,097	6	
7	VLG CORP.--LINE OF CREDIT		X	OPERATIONS	NONE					VARIES	63,463	7	
8	RELATED PARTY-CPT		X	OPERATIONS	NONE					VARIES	1,895	8	
9	TOTAL Facility Related				\$56,000.00		\$ 5,957,425	\$ 5,916,215			\$ 495,800	9	
	B. Non-Facility Related*												
10	INTEREST INCOME										(46,901)	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (46,901)	14	
15	TOTALS (line 9+line14)						\$ 5,957,425	\$ 5,916,215			\$ 448,899	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Facility Name & ID Number Alden Village Health Facility

0038455

Report Period Beginning:

01/01/00

Ending:

12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	\$	47,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	44,594	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(2,406)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	47,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	44,594	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	41,347	8		
	1996	41,692	9		
	1997	43,638	10		
	1998	44,481	11		
	1999	44,594	12		

LINE4: 2000 ACCRUAL BASED ON 5% INCREASE OF PRIOR YEAR BILL: \$44,594 X 1.05=47,000

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

X. BUILDING AND GENERAL INFORMATION:

A.
Square Feet:
30,726

B. General Construction Type:

Exterior
BRICK

Frame
STEEL

Number of Stories
1

C.
Does the Operating Entity?

☐ (a) Own the Facility
☒ (b) Rent from a Related Organization.
☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D.
Does the Operating Entity?

☐ (a) Own the Equipment
☐ (b) Rent equipment from a Related Organization.
☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E.
List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F.
Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES
☒ NO

If so, please complete the following:

1. Total Amount Incurred:
N/A

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	BILDING		1992	\$ 135,758	1
2					2
3	TOTALS			\$ 135,758	3

Facility Name & ID Number Alden Village Health Facility

0038455

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6	109		1992	1973	639,042		30	21,301	21,301	561,229	6
7			1992	1984	706,283	84,991	15	47,086	(37,905)	746,614	7
8											8
	Improvement Type**										
9	REPAIR HEATER PUMP, REPLACED TEMP. CONTROLLER		1992		2,131	213	10	213		1,722	9
10	WATER HEATER, MOTOR (HVAC), VALVE(HVAC), REPAIR		1993		9,288	409	5-15	409		7,889	10
11	CARPENTRY WORK, WATER HEATER REPAIR, WATER P.		1994		63,064	2,937	3-15	2,937		40,224	11
12	ALARM(FIRE) REPAIRS, BRICKWORK, INSTALL CIRCUITS		1995		185,123	10,689	3-25	10,689		68,832	12
13	VILLAGE CONSTRUCTION		1996		14,046	562	25	562		3,231	13
14	INSTALL FIRE DOOR		1996		2,977	198	15	198		959	14
15	REPLACE COMPRESSOR (HVAC) TEMP. SERV.		1997		1,825	365	5	365		1,278	15
16	J.D.&Son Roofing Co. (patched roof)		1998		1,700	170	10	170		453	16
17	CSI (replace condensing unit) hvac		1998		4,810	321	15	321		802	17
18	Atash Fire (install damper motor,detector)		1998		2,104	140	15	140		316	18
19	CSI-replace furnace equipment		1999		1,827	122	15	122		244	19
20	Great lakes auto-install automatic door		1999		8,107	811	10	811		1,081	20
21	new horizons-install display phone/digital phones		2000		1,726	72	10	72		72	21
22	climate serv-replace 12 hvac burners		2000		1,607	536	3	536		72	22
23	gt mechanical-replace 5 ton condensing unit		2000		1,950	260	5	260		536	23
24	system electric-install 100 amp disconnect and cable		2000		1,920	256	5	256		260	24
25	gt mechanical-repair roof		2000		1,583	53	5	53		256	25
26										53	26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$ 1,651,113	\$ 103,105		\$ 86,500	\$ (16,604)	\$ 1,436,121	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden Village Health Facility

0038455

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Related			1978	\$ 12,184	\$ 554	22	\$ 554		\$ 11,565	4
5	Party			1978	5,953	271	32	271		4,767	5
6	(Forum)										6
7											7
8											8
	Improvement Type**										
9	Related Party - AMS:										9
10	Leasehold Improvement - Remodeling			1993	5,378	223	various	223		115,184	10
11	Leasehold Improvement - Remodeling			1994	2,663	407	various	407		55,299	11
12											12
13	Related Party - Forum:										13
14	Leasehold Improvement - Remodeling			1980	19,102	955	20	955		19,102	14
15	Leasehold Improvement - Remodeling			1980	113		10			113	15
16	Leasehold Improvement - Remodeling			1986	32		6			32	16
17	Leasehold Improvement - Remodeling			1990	51		5			51	17
18	Leasehold Improvement - Remodeling			1991	12		5			12	18
19	Leasehold Improvement - Remodeling			1993	4,085	408	10	408		4,085	19
20	Leasehold Improvement - Remodeling			1993	3,199	330	9.7	330		3,058	20
21	Leasehold Improvement - SIGN			1994	258	21	10	21		145	21
22	Leasehold Improvement - DRYVIT			1994	437	44	12	44		244	22
23	Leasehold Improvement - NEW AC			1995	714	48	10	48		71	23
24	Leasehold Improvement - Roof			1997	961	51	10	51		760	24
25	Leasehold Improvement - Roof			1998	853	57	10	57		369	25
26	Leasehold Improvements-Roof			1985	809	54	19	54		175	26
27	Leasehold Improvements-Roof			1999	1,373	92	15	92		198	27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$ 58,177	\$ 3,514		\$ 3,514		\$ 215,231	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 602,501	\$ 50,211	\$ 50,211		various	\$ 183,578	37
38	Current Year Purchases	13,655	1,197	1,197		various	1,197	38
39	Fully Depreciated Assets	46,011	1,214	1,214		various	46,011	39
40								40
41	TOTALS	\$ 662,167	\$ 52,622	\$ 52,622			\$ 230,786	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	various	busses, van, engine	1998-2000	\$ 26,682	\$ 2,494	\$ 2,494		3	\$ 3,030	42
43										43
44										44
45										45
46	TOTALS			\$ 26,682	\$ 2,494	\$ 2,494			\$ 3,030	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 2,533,897	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 161,735	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 145,131	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ (16,604)	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 1,885,169	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$		52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$		57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: BOULEVARD BANK

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. ☒ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		<u>90</u>		\$			3
4	Additions							4
5								5
6								6
7	TOTAL		<u>90</u>		\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease

N/A
N/A

9. Option to Buy: ☐ YES ☒ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 5,769 Description: COPY MACHINE LEASE

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>RELATED PARTY</u>	<u>VARIOUS</u>	\$ <u>1009</u>	\$ <u>12,113</u>	17
18	<u>SEE PAGE 8A</u>				18
19					19
20					20
21	TOTAL		\$ <u>1009</u>	\$ <u>12,113</u>	21

10. Effective dates of current rental agreement:

Beginning 4/1/2000

Ending 3/31/2019

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. 12/31/01 \$ 672,000

13. 12/31/02 \$ 672,000

14. 12/31/03 \$ 672,000

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p>SKILLED NURSING IS ALREADY ON SITE</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility		2	3	4
		Drop-outs	Completed	Contract	Total	
1	Community College Tuition	\$	\$	\$	\$	
2	Books and Supplies					
3	Classroom Wages (a)					
4	Clinical Wages (b)					
5	In-House Trainer Wages (c)					
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS	\$	\$	\$	\$	
10	SUM OF line 9, col. 1 and 2 (e)	\$				

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ NA

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 480	\$		\$ 480	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts				(8)		(8)	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):						4,066		4,066	13
14	TOTAL			\$		\$ 480	\$ 4,058		\$ 4,538	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 109,969	\$ 109,969	1
2	Cash-Patient Deposits	2,000	2,000	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (6,000))	1,203,427	1,203,427	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	91,348	98,749	6
7	Other Prepaid Expenses	14,260	14,260	7
8	Accounts Receivable (owners or related parties)	1,371,561	1,789,665	8
9	Other(specify): <u>escrows</u>		1,300,758	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,792,564	\$ 4,518,828	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		580,000	13
14	Buildings, at Historical Cost		3,314,649	14
15	Leasehold Improvements, at Historical Cost	425,705	425,705	15
16	Equipment, at Historical Cost	228,078	592,078	16
17	Accumulated Depreciation (book methods)	(365,666)	(620,601)	17
18	Deferred Charges	32,780	32,780	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs		229,227	20
21	Restricted Funds		(10,915)	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 320,897	\$ 4,542,922	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,113,461	\$ 9,061,750	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 785,211	\$ 785,711	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	46,029	46,029	28
29	Short-Term Notes Payable		41,000	29
30	Accrued Salaries Payable	210,951	210,951	30
31	Accrued Taxes Payable (excluding real estate taxes)	64,174	64,174	31
32	Accrued Real Estate Taxes(Sch.IX-B)	47,000	47,000	32
33	Accrued Interest Payable		35,497	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	386,295	386,295	35
	Other Current Liabilities(specify):			
36	<u>third party</u>	1,454,259	1,454,259	36
37	<u>due to idpa/others/misc</u>	36,469	36,469	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,030,388	\$ 3,107,386	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,875,215	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 5,875,215	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,030,388	\$ 8,982,600	46
47	TOTAL EQUITY(page 18, line 24)	\$ 83,073	\$ 79,150	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,113,461	\$ 9,061,750	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 187,822	1
2	Restatements (describe):		2
3	adjustments made by external auditors after 1999 report		3
4	was filed: no effect on allowable costs (bad debt exp was		4
5	adjusted)	58,015	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 245,837	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(162,764)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (162,764)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 83,073	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Page 19

Facility Name & ID Number Alden Village Health Facility# 0038455Report Period Beginning: 01/01/00Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,849,537	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,849,537	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,801	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,801	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Adj's made to prior year expenses. Since prior year reports		28
28a	were not used, we've made no offsetting adjs on pg 5 or 5a	14,300	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 14,300	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,866,638	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,140,862	31
32	Health Care	2,487,796	32
33	General Administration	1,159,533	33
	B. Capital Expense		
34	Ownership	823,648	34
	C. Ancillary Expense		
35	Special Cost Centers	77,351	35
36	Provider Participation Fee	340,212	36
	D. Other Expenses (specify):		
37	Note: this does not balance to page 3 & 4 due to related party		37
38	amounts entered onto page 3 & 4.		38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,029,402	40
41	Income before Income Taxes (line 30 minus line 40)**	(162,764)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (162,764)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? not yet done If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

**** Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Alden Village Health Facility

0038455

Report Period Beginning: 01/01/00

Ending:

12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,140	2,534	\$ 66,383	\$ 26.20	1
2	Assistant Director of Nursing	183	183	4,477	24.46	2
3	Registered Nurses	21,389	22,922	501,900	21.90	3
4	Licensed Practical Nurses	10,450	11,385	224,470	19.72	4
5	Nurse Aides & Orderlies	116,887	122,839	1,151,120	9.37	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,264	1,410	19,525	13.85	9
10	Activity Assistants					10
11	Social Service Workers	2,269	2,269	36,435	16.06	11
12	Dietician	10,241	10,828	77,582	7.16	12
13	Food Service Supervisor	1,872	1,936	33,032	17.06	13
14	Head Cook	5,856	6,264	45,181	7.21	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,800	2,080	38,500	18.51	17
18	Housekeepers	15,083	15,831	143,768	9.08	18
19	Laundry	8,490	9,086	88,648	9.76	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	2,254	2,786	40,976	14.71	22
23	Office Manager	4,989	5,400	32,660	6.05	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	6,745	7,266	104,757	14.42	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	211,912	225,019	\$ 2,609,414 *	\$ 11.60	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	721	34,664	10A-3	40
41	Occupational Therapy Consultant	245	11,185	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	74	3,811	11-3	44
45	Social Service Consultant	25	1,262	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,065	\$ 50,922		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name		Function	%	Amount		Description		Amount	Description		Amount
DAVE ZARUBA		ADMINISTRATOR		\$	71,247	Workers' Compensation Insurance		\$ 39,880	IDPH License Fee		\$
						Unemployment Compensation Insurance		40,273	Advertising: Employee Recruitment		3,319
						FICA Taxes		198,349	Health Care Worker Background Check		
						Employee Health Insurance		50,480	(Indicate # of checks performed)		
						Employee Meals		23,346	Misc. Subscriptions(IHCA and others)		5,341
						Illinois Municipal Retirement Fund (IMRF)*			City and County Licenses & Inspections		650
						RELATED PARTY		34,930	Misc. Inspections		1,205
						DENTAL / LIFE INSURANCE		1,109	Related Party		343
						EMP. RELATIONS /EMP. VACC		11,899			
						PAYROLL MISC. COST / 401K MATCH		988			
									Less: Public Relations Expense		()
									Non-allowable advertising		()
									Yellow page advertising		()
TOTAL (agree to Schedule V, line 17, col. 1)						TOTAL (agree to Schedule V, line 22, col.8)		\$ 401,254	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 10,858
(List each licensed administrator separately.)				\$	71,247						
B. Administrative - Other											
Description				Amount							
				\$							
TOTAL (agree to Schedule V, line 17, col. 3)				\$							
(Attach a copy of any management service agreement)											
C. Professional Services						E. Schedule of Non-Cash Compensation Paid to Owners or Employees					
Vendor/Payee		Type		Amount		Description		Line #	Amount		
ALDEN MANAGEMENT SVS		MGMT. FEES		\$	439,883				\$		
BALCKMAN KALLICK		ACCOUNTING			16,880						
KENNETH F./B. GREENBURG H.		LEGAL			11,455						
ALDEN DESIGN		DESIGN FEES			2,992						
ALDEN BENNET CONSTRUCTION		CONSTR. FEES			4,815						
BENBROOK ASSOC.		consulting for dd			145,193						
US GAS & ENERGY		UTILITY CONSULT			491						

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2		3		4		5		6		7		8		9		10		11		12		13	
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year																				
					FY1997		FY1998		FY1999		FY2000		FY2001		FY2002		FY2003		FY2004		FY2005				
1	WASH CONDENSOR	5/93	\$ 3,238	10	\$ 324	\$ 324	\$ 324	\$ 324	\$ 324	\$ 324	\$ 324	\$ 324	\$ 324	\$ 324	\$ 324	\$ 324	\$ 324	\$ 324	\$ 324	\$ 324	\$ 324	\$ 324	\$ 324	\$ 324	\$ 324
2	Painting	3/94	30,934	3	1,719	0																			
3	Circulator Pump	11/94	2,100	10	210	210	210	210	210	210	210	210	210	210	210	210	210	210	210	210	210	210	210	210	210
4	Boiler Repair	11/94	1,893	3	526	0																			
5	Air Cond. Repair	11/94	2,198	3	610	0																			
6	Boiler Repair	11/94	3,503	3	972	0																			
7	Condenser Repair	11/94	3,892	3	1,082	0																			
8	Compressor - A/C	11/94	2,191	15	146	146	146	146	146	146	146	146	146	146	146	146	146	146	146	146	146	146	146	146	146
9	Air Cond. Repair	11/94	2,726	3	757	0																			
10	Hot Water Tank Repair	11/94	1,890	3	525	0																			
11	Circulator Pump	1/95	1,621	10	162	162	162	162	162	162	162	162	162	162	162	162	162	162	162	162	162	162	162	162	0
12	Boiler Repair	4/95	4,913	3	1,638	409	0																		
13	Painting	6/95	1,610	3	537	224	0																		
14	Heater Repair	9/95	2,553	3	851	604	0																		
15	Heater Repair	10/95	2,966	3	989	705	0																		
16	PAINTING	1/96	840	3	280	280	0																		
17	PAINTING	3/96	12,300	3	4,100	4,100	683	0																	
18	PAINTING	3/96	966	3	322	322	54	0																	
19	Continued on page 22A																								
20	TOTALS		\$ 82,335		\$ 15,750	\$ 7,486	\$ 1,579	\$ 842	\$ 842	\$ 842	\$ 842	\$ 842	\$ 842	\$ 842	\$ 842	\$ 842	\$ 842	\$ 842	\$ 842	\$ 842	\$ 626	\$ 321			

<p>Facility Name & ID Number <u>Alden Village Health Facility</u></p> <p>XX. GENERAL INFORMATION:</p> <p>(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>NO</u></p> <p>(2) Are there any dues to nursing home associations included on the cost report? <u>YES</u> If YES, give association name and amount. <u>Illinois Healthcare Asso. \$5,341</u></p> <p>(3) Did the nursing home make political contributions or payments to a political action organization? <u>YES</u> If YES, have these costs been properly adjusted out of the cost report? <u>YES</u></p> <p>(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>NO</u> If YES, what is the capacity? _____</p> <p>(5) Have you properly capitalized all major repairs and equipment purchases? <u>YES</u> What was the average life used for new equipment added during this period? <u>10 YEARS</u></p> <p>(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ <u>51,310</u> Line <u>10</u></p> <p>(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>YES</u> If NO, attach a complete explanation.</p> <p>(8) Are you presently operating under a sale and leaseback arrangement? <u>NO</u> If YES, give effective date of lease. _____</p> <p>(9) Are you presently operating under a sublease agreement? _____ YES <u>X</u> NO</p> <p>(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. _____</p> <p>(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ <u>340,212</u> This amount is to be recorded on line 42 of Schedule V.</p> <p>(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? <u>NO</u> If YES, attach an explanation of the allocation.</p>	<p style="text-align: center;">STATE OF ILLINOIS</p> <p># <u>0038455</u> Report Period Beginning: <u>01/01/00</u> Ending: <u>12/31/00</u></p> <p>(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? <u>YES</u></p> <p>(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? <u>NO</u> For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.</p> <p>(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ <u>23,346</u> Has any meal income been offset against related costs? <u>NONE</u> Indicate the amount. \$ <u>N/A</u></p> <p>(16) Travel and Transportation a. Are there costs included for out-of-state travel? <u>N/A</u> If YES, attach a complete explanation. b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>NO</u> If YES, please indicate the amount of income earned from such a program during this reporting period. \$ <u>N/A</u> c. What percent of all travel expense relates to transportation of nurses and patients? <u>0%</u> d. Have vehicle usage logs been maintained? <u>N/A</u> e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>N/A</u> f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>N/A</u> g. Does the facility transport residents to and from day training? <u>N/A</u> Indicate the amount of income earned from providing such transportation during this reporting period. \$ <u>N/A</u></p> <p>(17) Has an audit been performed by an independent certified public accounting firm? <u>YES</u> Firm Name: <u>Blackman Kallick Bartelstein, LLP</u> The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? <u>NO</u> If no, please explain. <u>NOT YET COMPLETED</u></p> <p>(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? <u>YES</u></p> <p>(19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? <u>YES</u> Attach invoices and a summary of services for all architect and appraisal fees.</p>
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STATE OF ILLINOIS

Page 22A

Facility Name & ID Number Alden Village Health Facility

0038455

Report Period Beginning:

01/01/00

Ending:

12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	PAINTING	4/96	966	3	\$ 322	\$ 322	\$ 81	\$ 0	\$	\$	\$	\$	
2	PAINTING	2/96	1,150	3	383	383	32	0					
3	PAINTING	8/96	966	3	322	322	188	0					
4	PAINTING	8/96	966	3	322	322	188	0					
5	PAINTING	7/96	464	3	155	155	77	0					
6	PAINTING	5/96	966	3	322	322	107	0					
7	PAINTING	6/96	966	3	322	322	134	0					
8	WATER PIPE REPLAC	7/95	1,908	15	127	127	127	127	127	127	127	127	127
9	ROOF REPAIR	9/96	3,345	10	334	334	334	334	334	334	334	334	334
10	PAINTING	10/96	966	3	322	322	242	0					
11	PAINTING	12/96	828	3	276	276	253	0					
12	PAINTING	10/96	966	3	322	322	242	0					
13	PAINTING	11/96	828	3	276	276	230	0					
14	repairs for rooftop	2/97	2,891	3	883	964	964	80	0				
15	replace compressor	7/97	3,596	3	599	1,199	1,199	599	0				
16	med. therm huper/hypoth	10/97	2,295	3	191	765	765	574	0				
17	Climate Serv.(repair A/C	6/98	3,650	3		710	0	0	0	0			
18	CSI replace motor,blower	10/98	2,620	3		218	0	0	0	0			
19	Continued on page 22B												
20	TOTALS		30,337		\$ 5,478	\$ 7,661	\$ 5,163	\$ 1,714	\$ 461	\$ 461	\$ 461	\$ 461	461

STATE OF ILLINOIS

Page 22B

Facility Name & ID Number Alden Village Health Facility

0038455

Report Period Beginning: 01/01/00

Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	CSI (replace blowers,housing,sh	10/98	2,115	3		176	705	705	529	0			
2	PAINTING *	3/98	2,087	3		580	696	696	116	0			
3	PAINTING *	6/98	3,050	3		593	1,017	1,017	424	0			
4	PAINTING *	9/98	1,823	3		203	608	608	405	0			
5	PAINTING *	12/98	2,038	3		57	679	679	623	0			
6	Climate Serv.-intstall thermom.	8/99	1,502	3			209	501	501	291	0		
7	Painting>\$1,500 1999	7/99	8,929	3			1,488	2,976	2,976	1,489	0		
8	GT Mechanical (repair A/C)	5/00	1,572	3				349	524	524	175		
9	Capps Plumbing (repair main ar	11/00	1,855	3				103	618	618	516		
10	Painting>\$1,500 for 2000	07/01	13,129	3				2,188	4,376	4,376	2,188	0	
11													
12	Totals from Page 22...		82,335		15,750	7,486	1,579	842	842	842	842	626	321
13	Totals from Page 22A...		30,337		5,478	7,661	5,163	1,714	461	461	461	461	461
14													
15													
16													
17													
18													
19													
20													
21													
22													
	TOTALS		150,772		\$ 21,228	\$ 16,756	\$ 12,144	\$ 12,378	\$ 12,395	\$ 8,601	\$ 4,182	\$ 1,087	782